

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 516

## CERTIFICATE OF DEATH

03861

Reg. Dist. No. 194

## 1. PLACE OF DEATH:

County HOWARD  
 City or town HIGHLAND - RURAL  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 months  
 Hospital, institution, or street address where death occurred:  
HIGHLAND - DAYTON ROAD  
 How long in hospital or institution?                     

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MARYLAND County HOWARD  
 City or town HIGHLAND - RURAL  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. HIGHLAND - DAYTON ROAD  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war                     

## 3. (a) FULL NAME

WALTER WILLIAM DAVIS

## 3. (b) Social Security Number

4. Sex MALE 5. Color or race COL. 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife BERTIE ALICE DAVISB. (c) If alive, give age 74 years7. Birth date of deceased (mo., day, yr.) NOT KNOWN 1872

8. AGE: Years 74 Months              Days              If less than one day              hrs.              min.

9. Birthplace HOWARD COUNTY, MD.  
 (Town, county, and state)

10. Usual occupation LABORER11. Industry or business FARM12. Name NOT KNOWN13. Birthplace HOWARD COUNTY, MD.14. Maiden name NOT KNOWN15. Birthplace HOWARD COUNTY, MD.16. Informant BERTIE ALICE DAVISAddress HIGHLAND, MD.

17. BURIAL Date thereof 4/25/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory HOPKINS CHAPELLocation HIGHLAND, MD.18. Funeral director ROBT L. SNOWDENAddress ROCKVILLE, MD.

19. 4/24 46 Maria G. Whitaker  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 22 1946 7<sup>20</sup> P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/8 1946 to 4/19 46

and that I last saw him alive on 4/19 1946

Immediate cause of death CACHEXIA DURATION 2 mos.

Due to CARCINOMA of the PROSTATE 2 yrs  
WITH METASTASES

Due to                     Other conditions   

(Include pregnancy within 8 months of death)

Major findings of operations                     Date of op.                     Autopsy results                     

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide                      Date of                     Where did injury occur?                      (City or town) (County) (State)Injured at home, farm, industry, public place (where?)                     Means of injury                      Injured at work?                     23. SIGNATURE Charles S. Whitaker, M.D. M. D. or other

CLARKSVILLE Address                      Date signed 4/22/46

481

RECEIVED

APR 29 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 972

## CERTIFICATE OF DEATH

03862

Reg. Dist. No.

194

## 1. PLACE OF DEATH

County HOWARD  
 City or town RURAL - DAYTON  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 years  
 Hospital, institution, or street address where death occurred:  
TRIADELPHIA ROAD  
 How long in hospital or institution?       

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County HOWARD  
 City or town RURAL - DAYTON  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. TRIADELPHIA ROAD  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war       

## 3. (a) FULL NAME

JOHN HENRY DORSEY

## 3. (b) Social Security Number

4. Sex MALE 5. Color or race COL 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife MARY CATHERINE DORSEY6. (c) If alive, give age 72 years7. Birth date of deceased (mo., day, yr.) APRIL 22, 1871

8. AGE: Year 74 Months 11 Day 25 If less than one day  
 .....hrs. ....min.

9. Birthplace HOWARD COUNTY, MO.  
 (Town, county, and state)

10. Usual occupation FARMER11. Industry or business FARM12. Name CHARLES DORSEY13. Birthplace HOWARD COUNTY, MO.14. Maiden name SARAH MARGARET CARTER15. Birthplace MARYLAND16. Informant MARY CATHERINE DORSEYAddress CLARKSVILLE

17. Burial Date thereof 4 20 46  
 (Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory St. Johns ChapelLocation Nightingale Maryland18. Funeral director Robert SnowdenAddress Rochester, Ind

19. 4/17 19 46 Marie A. Whitaker  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 16 46 5<sup>30</sup> A M

21. I CERTIFY that death occurred on the date above related; that I attended deceased from

FEBRUARY 15 1946 to FEB 22 1946  
 and that I last saw him alive on APRIL 7 1946

Immediate cause of death

CORONARY ARTERY  
THROMBOSIS

DURATION

2 mins

Due to CORONARY ARTERY SCLEROSIS 5 years

Due to ARTERIO SCLEROSIS 10 years

Other conditions GENERALIZED

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.       

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide        Date of       

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)       Means of injury        Injured at work?       23. SIGNATURE Charles S. Whitaker M.D.

M. D. or other

Address Clarks ville, Md. Date signed 4/16/46

RECEIVED

APR 29 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03863

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Howard  
 City or town Dorsey  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 23 yrs  
 Hospital, institution, or street address where death occurred:  
Linden ave  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Howard  
 City or town Dorsey  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Linden ave  
 (If rural, give LOCATION)  
none  
 2. (a) If veteran, name war none

## 3. (a) FULL NAME

Bernard Strickler Harman

## 3. (b) Social Security Number

213-03-7628

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Edith J. Harman

7. Birth date of deceased (mo., day, yr.) July 8 - 1890  
 B. (c) If alive, give age 56 years

8. AGE: Years 55 Months 9 Days 12 If less than one day hrs. min.

9. Birthplace Jessup Md  
 (Town, county, and state)

10. Usual occupation Salesman

11. Industry or business H. A. Davis & Son

12. Name William M. Harman

13. Birthplace A. A. Co Md

14. Maiden name Mary Taylor

15. Birthplace Baltimore Md

16. Informant Miss Edith J. Harman

Address Dorsey Md (wife)

17. Burial Date thereof 4/23/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Zion Cemetery

Location Dorsey, Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 4-22 19 46 Arthur D. Rich  
 Registered by Registrar Presch

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 20 19 46 at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 45 to Apr 20 19 46

and that I last saw him alive on Apr 20 19 46

Immediate cause of death Carcinoma of bladder

Due to General Carcinomatosis

Due to 4 mo

Other conditions Myocardial

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of bladder

Date of op. Oct 46

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. B. Brumbaugh

Address 3629 M. D. or other

Date signed 4/29/46

13280

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASH. D.C.

OFFICE OF THE ASSISTANT ATTORNEY GENERAL

WASHINGTON, D.C.

1900

1901

1902

1903

1904

1905

1906

1907

1908

1909

1910

1911

1912

1913

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

1924

1925

1926

1927



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-0

03864

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County HowardCity or town Ellicott City Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Ellicott City Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. Candling Road  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Grayson E Mathena

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Anne K Mathena

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1908

8. AGE: Years Months Days If less than one day

37 6 17

hrs. min.

9. Birthplace Penn  
(Town, county, and state)10. Usual occupation Fireman

11. Industry or business

12. Name Chas E. Mathena13. Birthplace W. Va.14. Maiden name Bessie E. Crew15. Birthplace W. Va.16. Informant Anne MathenaAddress Ellicott City Md17. Burial Date thereof 4-24-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St JohnsLocation Ellicott City Md18. Funeral director F. C. NijubathamAddress Ellicott City Md19. April 23, 1946 John B. Lughan  
(Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 21, 1946 at 4 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/19 1946 to 4/21 1946  
and that I last saw him alive on 4/21 1946

Immediate cause of death

Carcinoma of lung  
(Bronchogenic)

DURATION

3 months

Due to

Due to

Other conditions none

(Include pregnancy within 8 months of death)

Major findings of operations Bronchogenic Carcinoma  
of lung Date of op. 3/18/46Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George E. Buntorf M. D. or otherAddress Ellicott City Md Date signed 4/22/46

RECEIVED

APR 25 1946

BUREAU V. E.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 198

## 1. PLACE OF DEATH:

County HowardCity or town Long Green  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Long Green  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Harry Edward Mohaworth

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, or divorced

Married

## 6. (b) Name of husband or wife

Annie Laura Mohaworth

## 7. Birth date of deceased (mo., day, yr.)

July 7 18746. (c) If alive, give age 73 years

## 8. AGE:

Years

Months

Days

If less than one day

71829

hrs.

min.

## 9. Birthplace

M. Long Green, Md.  
(Town, county and state)

## 10. Usual occupation

Retail Farmer

## 11. Industry or business

MOTHER FATHER

## 12. Name

Eli Mohaworth

## 13. Birthplace

Md.

## 14. Maiden name

Mary Ann Leakin

## 15. Birthplace

unknown

## 16. Informant

Annie Laura Mohaworth

## Address

RFD # 3 Mt Airy, Md.

## 17.

(Burial, cremation, or removal, Which?)

## Date thereof

April 10 1946  
(month) (day) (year)

## Cemetery or crematory

Howard Chapel Church

## Location

Long Green, Md.

## 18. Funeral director

J. B. Beall Inc.

## Address

Damascus, Maryland

## 19.

4-10-19 46E. Paul Martin  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 25 1946 to April 6 1946  
and that I last saw him alive on April 6 1946

Immediate cause of death

Coronary Occlusion

DURATION

15 min.

Due to

Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. M. Han  
Mt Airy, Md.

M. D. or other

Address

Date signed 4/7/46

MEMO

TO: MR. TOLSON

FROM: MR. [illegible]

SUBJECT: [illegible]

RECEIVED  
APR 17 1946  
BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

74-192

## 1. PLACE OF DEATH:

County HowardCity or town Rural - Sykesville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 1/2

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HowardCity or town Rural - Sykesville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced Single

B. (b) Name of husband or wife \_\_\_\_\_

B. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 18698. AGE: Years 77 Months 2 Days 20 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace MD  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farm12. Name John S. Ridgely13. Birthplace MD14. Maiden name Louise Ann Jarvis15. Birthplace MD16. Informant Mr. Ridgely, JamesAddress Sykesville, Md.17. Buried Date thereof 4-13-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium Family Burial GroundsLocation Near Sykesville, Md.18. Funeral director C. Harry WeeAddress Sykesville, Md.19. April 13 19 46 C. Harry Wee  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 19 46, at 7:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/8 19 46 to 4/10 19 46and that I last saw him alive on 4/8 19 46

Immediate cause of death \_\_\_\_\_

Due to Coronary Artery DiseaseDue to Myocardial Infarction

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

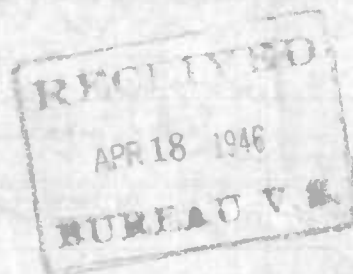
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE HA Barnes MDAddress Sykesville Md Date signed 4/11/46

SYSTEM TO TRANSFER THE STATE OF ILLINOIS

STATE OF ILLINOIS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (236)

## CERTIFICATE OF DEATH

Reg. Dist. No. 190

## 1. PLACE OF DEATH:

County HowardCity or town Elkridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred: 1How long in hospital or institution? 1

## 3. (a) FULL NAME

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Wm. L. C.7. Birth date of deceased (mo., day, yr.) August 26 - 18718. AGE: Years 74 Months 7 Days 24 If less than one day hrs. min.9. Birthplace Elkridge, Md.  
(Town, county, and state)10. Usual occupation tool maker

11. Industry or business

12. Name Elizabeth Smithson13. Birthplace Maryland14. Maiden name Rebecca F. Carney15. Birthplace Maryland16. Informant Mrs. Mary L. SmithsonAddress 5831 Victoria Ave.17. (Burial, cremation, or removal. Which?) burial Date thereof 4/22/46  
(month) (day) (year)Cemetery or crematory St. Augustine Cmp.Location Elkridge, Md.18. Funeral director John HowardsonAddress 401-03 Baltimore19. April 19, 46 (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HowardCity or town Elkridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5831 Victoria Ave.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 194621. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 44 to Sept 19, 46and that I last saw him alive on Apr 18, 1946Immediate cause of death hypertensionDURATION 3 daDue to hypertensionDue to hypertensionOther conditions hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. B. Brown

M. D. or other

Address Elkridge Md. Date signed 4/19/46

RECEIVED

APR 20 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-2

## CERTIFICATE OF DEATH

113868

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County HOWARD  
 City or town ELLICOTT CITY MARYLAND  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 MONTH AND 14 DAYS

Hospital, institution, or street address where death occurred:

PINEL CLINIC - ELLICOTT CITY - MDHow long in hospital or institution? 1 MONTH AND 14 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County BALTIMORE CITYCity or town BALTIMORE  
 (If outside city or town limits, write RURAL and give nearest town)Street No. 700 CHUMLEIGH ROAD  
 (If rural, give LOCATION)

2. (a) If veteran, name war .....

## 3. (a) FULL NAME

MARY ELIZABETH WOLFE

## 3. (b) Social Security Number

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED

6. (b) Name of husband or wife JOHN CALVIN WOLFE Sr.

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-2-1866

8. AGE: Years 80 Months 3 Days 17 It less than one day ..... hrs. .... min.

9. Birthplace GERMANY Pomerania  
 (Town, county, and state)10. Usual occupation HOUSEWIFE

## 11. Industry or business

12. Name AUGUST REDLIN13. Birthplace GERMANY14. Maiden name EMILIA SCHMELLING15. Birthplace GERMANY16. Informant SETH A. WOLFE Sr.Address 700 CHUMLEIGH RD. BALTO. MD.17. Removal Date thereof 4/21/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Groten Union Cem.Location Groten, South Dakota18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. Apr 20 19 46 A. W. Hedrich  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 19<sup>th</sup> 19 46 at 7 30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 6<sup>th</sup> 19 46 to APRIL 19<sup>th</sup> 19 46and that I last saw her alive on APRIL 19<sup>th</sup> 19 46Immediate cause of death CEREBRAL HEMORRHAGE DURATION 5 HOURS

Due to .....

Due to .....

Due to .....

Other conditions SENILE PSYCHOSIS 4 YEARSCONFUSED TYPE

(Include pregnancy within 8 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Helmut Prager M.D.Address ELLICOTT CITY MD Date signed 4/19/1946